2027

Annual Notice of Change

HumanaChoice SNP-DE H5216-332 (PPO D-SNP)

This is a Highly Integrated Dual Eligible (HIDE) Special Needs Plan.

Louisiana

Humana®

Let's review your **2027 plan changes**

Thank you for trusting Humana with your HumanaChoice SNP-DE H5216-332 (PPO D-SNP) for 2026. Inside, you'll find the Annual Notice of Change, which shows you important plan changes.

We're here to make it easier for you to navigate your benefits. Though some benefits are changing, we've listened to our members and focused on protecting what matters most. We are committed to stable coverage, individualized care and the trust of members, providers and communities we serve.

Essential benefits you can count on

Dental, vision and hearing

Prescription drug coverage

$0 preventive care screenings*

A closer look at your 2027 plan changes

Get a personalized, interactive look at what's changing with your 2027 plan. We're providing all the details you need to renew with confidence.

No action needed to keep your plan.

Upcoming dates to explore your options:

- ▶ **Today**
  New! Compare your 2026 and 2027 plan details at **Humana.com/Renewal**
- **October 15**
  Medicare Open Enrollment begins
- **December 7**
  Last day for Open Enrollment
- **January 1**
  Plan changes take effect

Here's what you can do next

For your complete, personalized view, **scan the QR code** to sign in or sign up for MyHumana or visit

Humana.com/Renewal

If you'd like to keep your current plan, no action is needed. Your plan will renew on January 1, 2027.

*Applies to covered services from in-network providers.

HumanaChoice SNP-DE H5216-332 (PPO D-SNP) offered by Humana Insurance Company

Annual Notice of Change for 2027

You're enrolled as a member of HumanaChoice SNP-DE H5216-332 (PPO D-SNP).

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 - December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2026, you'll stay in HumanaChoice SNP-DE H5216-332 (PPO D-SNP).
- To change to a **different plan**, visit Medicare.gov or review the list in the back of your *Medicare & You 2027* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at **Humana.com/PlanInformation** or call Customer Care at 800-457-4708 (TTY users call 711) to get a copy by mail.

More Resources

- This material is available for free in Spanish.
- Call Customer Care at 800-457-4708 (TTY users call 711) for more information. Hours are 8 a.m. to 8 p.m. seven days a week from Oct. 1 – Mar. 31 and 8 a.m. to 8 p.m. Monday – Friday from Apr. 1 – Sept. 30. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day. This call is free.
- This information is available in different formats, including braille, large print, and audio. Please call Customer Care at the number listed above if you need plan information in another format.

About HumanaChoice SNP-DE H5216-332 (PPO D-SNP)

- HumanaChoice SNP-DE H5216-332 (PPO D-SNP) is a Dual Eligible Special Needs PPO SNP plan with a Medicare contract and a contract with the Louisiana Medicaid program. Enrollment in this Humana plan depends on contract renewal. Our plan also has a written agreement with the Louisiana Medicaid program to coordinate your Medicaid benefits.
- When this material says "we," "us," or "our," it means Humana Insurance Company. When it says "plan" or "our plan," it means HumanaChoice SNP-DE H5216-332 (PPO D-SNP).
- **If you do nothing by December 7, 2026, you'll automatically be enrolled in HumanaChoice SNP-DE H5216-332 (PPO D-SNP).** Starting January 1, 2027, you'll get your medical and drug coverage through HumanaChoice SNP-DE H5216-332 (PPO D-SNP). Go to Section 2 for more information about how to change plans and deadlines for making a change.

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OMB Approval 0938-1051 (Expires: July 31, 2029)

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Lists the names, addresses, phone numbers, and other contact information for a variety of helpful resources in your state.

Summary of Important Costs for 2027

Cost	2026 (this year)		2027 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Monthly plan premium	**$0 or up to $32.90**		**$0 or up to $17**	
Deductible	**$0**	**$0 or $283** combined in-network and out-of-network except for insulin furnished through an item of durable medical equipment.	**$0**	**$0** or you pay the same amount as you would with Original Medicare.
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	From network providers: **$9,250** If you are eligible for Medicare cost-sharing help under Medicaid, you most likely are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	From network and out-of-network providers combined: **$13,900** If you are eligible for Medicare cost-sharing help under Medicaid, you most likely are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	From network providers: **$9,850** If you are eligible for Medicare cost-sharing help under Medicaid, you most likely are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	From network and out-of-network providers combined: **$14,800** If you are eligible for Medicare cost-sharing help under Medicaid, you most likely are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.
Primary care office visits	**$0** copayment per visit	**$0 or 20%** of the total cost per visit	**$0** copayment per visit	**$0 or 20%** of the total cost per visit
Specialist office visits	**$0** copayment per visit	**$0 or 20%** of the total cost per visit	**$0** copayment per visit	**$0 or 20%** of the total cost per visit

Cost	2026 (this year)		2027 (next year)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Inpatient hospital stays Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	**$0** copayment per stay	**$0 or $2,230** copayment per stay	**$0** copayment per stay	**$0 or $2,241** copayment per stay
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage and Catastrophic Coverage Stages.) Not all tiers may include insulin. Please refer to your Prescription Drug Guide to confirm insulin coverage.	Part D drug coverage deductible If you receive Extra Help, your deductible is **$0**. Refer to your *LIS Rider* insert for your cost sharing amounts. If you **do not** receive Extra Help, the deductible is **$615**. **$0** for Tier 1 and Tier 2 **$615** for Tier 3, Tier 4, and Tier 5; except for covered insulin products and most adult Part D vaccines		**Part D drug coverage deductible** If you receive Extra Help, your deductible is **$0**. Refer to your *LIS Rider* insert for your cost sharing amounts. If you **do not** receive Extra Help, the deductible is **$700**. **$0** for Tier 1 and Tier 2 **$700** for Tier 3, Tier 4, and Tier 5; except for covered insulin products and most adult Part D vaccines	
	Copayment/Coinsurance during the Initial Coverage Stage:		**Copayment/Coinsurance during the Initial Coverage Stage:**	

Cost	2026 (this year)		2027 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	For a 30-day supply from a **retail pharmacy**: • Drug Tier 1: **$0** You pay no more than **$0** per month supply of each covered insulin product on this tier. • Drug Tier 2: **$0** You pay no more than **$0** per month supply of each covered insulin product on this tier. • Drug Tier 3: **25%** You pay no more than **25%** up to **$35** per month supply of each covered insulin product on this tier. • Drug Tier 4: **25%** You pay no more than **25%** up to **$35** per month supply of each covered insulin product on this tier. • Drug Tier 5: **25%** You pay no more than **25%** up to **$35** per month supply of each covered insulin product on this tier.		For a 30-day supply from a **retail pharmacy**: • **Drug Tier 1: $0** You pay no more than **$0** per month supply of each covered insulin product on this tier. • **Drug Tier 2: $0** You pay no more than **$0** per month supply of each covered insulin product on this tier. • **Drug Tier 3: 25%** You pay no more than **25%** up to **$35** per month supply of each covered insulin product on this tier. • **Drug Tier 4: 25%** You pay no more than **25%** up to **$35** per month supply of each covered insulin product on this tier. • **Drug Tier 5: 25%** You pay no more than **25%** up to **$35** per month supply of each covered insulin product on this tier.	

Cost	2026 (this year)		2027 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	For a 100-day supply from a **mail-order pharmacy** with preferred cost-sharing: • Drug Tier 1: **$0** You pay no more than **$0** per 3-month supply of each covered insulin product on this tier. • Drug Tier 2: **$0** You pay no more than **$0** per 3-month supply of each covered insulin product on this tier. • Drug Tier 3: **25%** You pay no more than **25%** up to **$105** per 3-month supply of each covered insulin product on this tier. • Drug Tier 4: **25%** You pay no more than **25%** up to **$105** per 3-month supply of each covered insulin product on this tier. • Drug Tier 5: Not available		For a 100-day supply from a **mail-order pharmacy** with preferred cost-sharing: • **Drug Tier 1: $0** You pay no more than **$0** per 3-month supply of each covered insulin product on this tier. • **Drug Tier 2: $0** You pay no more than **$0** per 3-month supply of each covered insulin product on this tier. • **Drug Tier 3: 25%** You pay no more than **25%** up to **$105** per 3-month supply of each covered insulin product on this tier. • **Drug Tier 4: 25%** You pay no more than **25%** up to **$105** per 3-month supply of each covered insulin product on this tier. • **Drug Tier 5:** Not available	

Cost	2026 (this year)		2027 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	For a 100-day supply from a **mail-order pharmacy** with standard cost-sharing: • Drug Tier 1: **$30** You pay no more than **25%** up to **$30** per 3-month supply of each covered insulin product on this tier. • Drug Tier 2: **$60** You pay no more than **25%** up to **$60** per 3-month supply of each covered insulin product on this tier. • Drug Tier 3: **25%** You pay no more than **25%** up to **$105** per 3-month supply of each covered insulin product on this tier. • Drug Tier 4: **25%** You pay no more than **25%** up to **$105** per 3-month supply of each covered insulin product on this tier. • Drug Tier 5: Not available		For a 100-day supply from a **mail-order pharmacy** with standard cost-sharing: • **Drug Tier 1: $30** You pay no more than **25%** up to **$30** per 3-month supply of each covered insulin product on this tier. • **Drug Tier 2: $60** You pay no more than **24%** up to **$60** per 3-month supply of each covered insulin product on this tier. • **Drug Tier 3: 25%** You pay no more than **25%** up to **$105** per 3-month supply of each covered insulin product on this tier. • **Drug Tier 4: 25%** You pay no more than **25%** up to **$105** per 3-month supply of each covered insulin product on this tier. • **Drug Tier 5:** Not available	
	Catastrophic Coverage: During this payment stage, you pay nothing for your covered Part D drugs.		**Catastrophic Coverage:** During this payment stage, you pay nothing for your covered Part D drugs.	

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

Cost	**2026** (this year)	**2027** (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Healthy Louisiana (Medicaid).)	**$0 or up to $32.90**	**$0 or up to $17** If you qualify for Extra Help with your prescription drug expenses, you may not have to pay a plan premium, or may pay a reduced amount.

Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket (MOOP) amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

Cost	**2026** (this year)	**2027** (next year)
In-network maximum out-of-pocket amount Cost-sharing paid by the beneficiary, Medicaid, and other secondary insurance contributes towards this out-of-pocket maximum. Because our members also get help from Healthy Louisiana (Medicaid), very few members ever reach this out-of-pocket maximum. If you are eligible for Medicaid help with Part A and Part B copayments and deductibles, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copayments and deductibles) from network providers **count** toward your in-network maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs **don't count** toward your maximum out-of-pocket amount.	**$9,250**	**$9,850** Once you've paid **$9,850** out-of-pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.

Cost	**2026** (this year)	**2027** (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copayments and deductibles) from in-network and out-of-network providers **count** toward your combined maximum out-of-pocket amount. Your plan premium and your costs for outpatient prescription drugs **don't count** toward your maximum out-of-pocket amount for medical services.	**$13,900** combined in-network and out-of-network	**$14,800** combined in-network and out-of-network Once you've paid **$14,800** out-of-pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Starting October 15, 2026 you can review the 2027 *Provider Directory* at **Humana.com/FindCare** to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at **Humana.com/FindCare**.
- Call Customer Care at 800-457-4708 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Customer Care at 800-457-4708 (TTY users call 711) for help. You may have a special enrollment period if your provider leaves the plan network. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your *Evidence of Coverage*.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Our network of pharmacies has changed for next year. Starting October 15, 2026 you can review the 2027 *Provider Directory* at **Humana.com/FindCare** to see which pharmacies are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at **Humana.com/FindCare**.
- Call Customer Care at 800-457-4708 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Provider Directory* .

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Customer Care at 800-457-4708 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

The Annual Notice of Change tells you about changes to your Medicare benefits and costs.

Services received at Rural Health Clinics, Federally Qualified Health Clinics, and Critical Access Hospitals may be subject to the Primary Care Physician or Specialist copay or coinsurance, as applicable, for 2027.

This spending allowance and Humana Cell Phone Benefit are a special supplemental benefit for members with specific chronic conditions who require intensive care coordination and are at a high risk of hospitalization or other adverse health outcomes. Qualifying conditions may include diabetes mellitus, cardiovascular disorders, chronic and disabling mental health conditions, chronic lung disorders, or chronic heart failure, among others. Some plans require at least two conditions. See the plan's Evidence of Coverage for details. If you use this program for rent or utilities, Housing and Urban Development (HUD) requires it to be reported as income. Contact your local HUD office with questions.

Cost	**2026** (this year)		**2027** (next year)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Special Supplemental Benefits for the Chronically Ill				
• Humana Cell Phone Benefit	Not Applicable	Not Applicable	**$0** copayment. If you are eligible for SSBCI, you MAY receive a cellular phone with unlimited talk, text, and data at no additional cost.	No Change
• Humana Healthy Options Allowance® All plan members receive this amount to buy approved over the counter (OTC) health and wellness products at participating retailers or through the plan's approved OTC mail order vendor. **Plus, members may also use this money for eligible groceries, utilities, rent, and more if they have certain qualifying chronic condition(s) and meet other program criteria.** Any unused amount rolls over each month and expires at the end of the plan year or	**$50** monthly allowance on a prepaid spending card.	Not Covered	No Change	**95%** coinsurance. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to **5%** of the allowed

Cost	2026 (this year)		2027 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
upon disenrollment, whichever occurs first.				amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Allergy shots and serum • For Medicare-covered allergy shots and serum, you pay: – at your primary care provider's office	**$0** copayment	**$0** copayment	No Change	**0% or 20%** of the total cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a **$0** copayment amount.
– at a specialist's office	**$0** copayment	**$0** copayment	No Change	**0% or 20%** of the total cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a **$0** copayment amount.
Ambulance services • For each Medicare-covered emergency transportation by ground, you pay:	**$0** copayment per date of service	**$0 or $335** copayment per date of service If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a	No Change	**$0 or $325** copayment per date of service If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a

Cost	**2026** (this year)		**2027** (next year)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
		$0 copayment amount.		**$0** copayment amount.
• For each Medicare-covered non-emergency transportation by ground, you pay:	**$0** copayment per date of service	**$0 or $335** copayment per date of service If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a **$0** copayment amount.	No Change	**$0 or $325** copayment per date of service If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a **$0** copayment amount.
Continuous Glucose Monitor – at a preferred pharmacy	Not Applicable	Not Applicable	**$0** copayment	Not Applicable
Dental services • Supplemental dental benefits:	**DEN379** **$0** copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. **$0** copayment for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. **$0** copayment for bridge recementation, bridges-pontic, crown recementation, panoramic film or diagnostic x-rays up to 1 every 5 years. **$0** copayment for	**DEN379** **$0** copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. **$0** copayment for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. **$0** copayment for bridge recementation, bridges-pontic, crown recementation, panoramic film or diagnostic x-rays up to 1 every 5 years. **$0** copayment for	**DEN384** **$0** copayment for amalgam filling, resin-based composite filling - back, resin-based composite filling - front up to 1 per tooth per surface every 2 years. **$0** copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. **$0** copayment for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. **$0** copayment for panoramic film or diagnostic x-rays up to 1 every 5 years.	**DEN384** **$0** copayment for amalgam filling, resin-based composite filling - back, resin-based composite filling - front up to 1 per tooth per surface every 2 years. **$0** copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. **$0** copayment for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. **$0** copayment for panoramic film or diagnostic x-rays up to 1 every 5 years.

Cost	2026 (this year)		2027 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	bridges-crown up to 2 every 5 years. **$0** copayment for crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime. **$0** copayment for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. **$0** copayment for emergency diagnostic exam up to 1 per year. **$0** copayment for emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. **$0** copayment for periodontal maintenance up to 4 per year. **$0** copayment for necessary anesthesia with covered service up to as needed with covered codes per year. **$0** copayment for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year. **$2,000** combined maximum benefit coverage amount	bridges-crown up to 2 every 5 years. **$0** copayment for crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime. **$0** copayment for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. **$0** copayment for emergency diagnostic exam up to 1 per year. **$0** copayment for emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. **$0** copayment for periodontal maintenance up to 4 per year. **$0** copayment for necessary anesthesia with covered service up to as needed with covered codes per year. **$0** copayment for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year. **$2,000** combined maximum benefit coverage amount	**$0** copayment for necessary nitrous oxide/analgesia with covered service up to 1 unit(s) per visit. **$0** copayment for bitewing x-rays, scaling for moderate inflammation up to 1 per year. **$0** copayment for emergency diagnostic exam, periodic oral exam, prophylaxis (cleaning) up to 2 per year. **$0** copayment for periodontal maintenance up to 4 per year. **$3,000** combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.	**$0** copayment for necessary nitrous oxide/analgesia with covered service up to 1 unit(s) per visit. **$0** copayment for bitewing x-rays, scaling for moderate inflammation up to 1 per year. **$0** copayment for emergency diagnostic exam, periodic oral exam, prophylaxis (cleaning) up to 2 per year. **$0** copayment for periodontal maintenance up to 4 per year. **$3,000** combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Cost	2026 (this year)		2027 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	per year for all diagnostic/preventive and comprehensive benefits.	per year for all diagnostic/preventive and comprehensive benefits. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.		
Hearing services • Supplemental hearing benefits:	**HER945** **$0** copayment for routine hearing exams up to 1 per year. **$0** copayment for follow-up provider visits up to unlimited per year. **$0** copayment for each Advanced level hearing aid up to 1 per ear every 3 years. Note: Includes 80 batteries per aid and 3 year warranty. Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase.	**HER945** TruHearing must be used for these services. If you choose to utilize another provider, you are responsible for all charges.	**HER120** **$0** copayment for routine hearing exams up to 1 per year. **$0** copayment for fitting up to 1 per year. **$0** copayment for follow-up provider visits up to 3 per year. **$0** copayment for each Level 1 prescription hearing aid up to 1 per ear per year. Note: Includes 3 years of batteries per non-rechargeable aid (up to 60 cells per ear, per year) and 3 year warranty. One fitting and three follow-up provider visits during first year following hearing aid purchase, with the original provider.	**HER120** **95%** coinsurance for routine hearing exams up to 1 per year. **95%** coinsurance for fitting up to 1 per year. **95%** coinsurance for follow-up provider visits up to 3 per year. **95%** coinsurance for each prescription hearing aid up to 1 per ear per year. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to

Cost	2026 (this year)		2027 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
				5% of the allowed amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Inpatient hospital care • For a Medicare-covered stay at a hospital, you pay:	**$0** copayment per stay	**$0 or $2,230** copayment per stay If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a **$0** copayment amount.	No Change	**$0 or $2,241** copayment per stay If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a **$0** copayment amount.
Inpatient mental health care • For a Medicare-covered stay at a hospital, you pay:	**$0** copayment per stay	**$0 or $2,230** copayment per stay If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a **$0** copayment amount.	No Change	**$0 or $2,241** copayment per stay If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a **$0** copayment amount.
• For a Medicare-covered stay at an inpatient psychiatric facility, you pay:	**$0** copayment per stay	**$0 or $2,080** copayment per stay If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a **$0** copayment amount.	No Change	**$0 or $2,091** copayment per stay If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a **$0** copayment amount.

Cost	2026 (this year)		2027 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Meal Program - Humana Well Dine®	**$0** copayment for Humana Well Dine® meal program. After your inpatient stay in either a hospital or a nursing facility, you may be eligible to receive 2 home delivered meals per day for 7 days (up to 14 meals). Meals must be requested within 30 days of discharge from your inpatient stay. Limited to 4 times per year.	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.	No Change	Covered
Outpatient diagnostic tests, therapeutic services and supplies • For lab services, you pay:				
– at your primary care provider's office	**$0** copayment	**$0** copayment	No Change	**0% or 20%** of the total cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a **$0** copayment amount.
– at a specialist's office	**$0** copayment	**$0** copayment	No Change	**0% or 20%** of the total cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a **$0** copayment amount.

Cost	2026 (this year)		2027 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Podiatry services • For each routine visit	**$0** copayment for routine podiatry visits up to 12 visit(s) per year.	**$0** copayment for routine podiatry visits up to 12 visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.	Not Covered	Not Covered
Post-discharge personal home care	**$0** copayment for a minimum of 4 hours per day, up to a maximum of 44 hours per year for certain in-home support services following a discharge from a skilled nursing facility or from an inpatient hospitalization. Qualified aides can offer assistance performing activities of daily living (ADLs). Activities of daily living are activities related to personal care. They include bathing or showering, dressing or undressing, grooming, toileting, continence care, transferring, walking or using mobility aids, eating or feeding assistance. Services must be initiated within 30	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.	**$0** copayment for a minimum of 4 hours per day, up to a maximum of 28 hours per year for certain in-home support services following a discharge from a skilled nursing facility or from an inpatient hospitalization. Qualified aides can offer assistance performing activities of daily living (ADLs). Activities of daily living are activities related to personal care. They include bathing or showering, dressing or undressing, grooming, toileting, continence care, transferring, walking or using mobility aids, eating or feeding assistance. Services must be initiated within 30	**95%** coinsurance for a minimum of 4 hours per day, up to a maximum of 28 hours per year for certain in-home support services following a discharge from a skilled nursing facility or from an inpatient hospitalization. Qualified aides can offer assistance performing activities of daily living (ADLs). Activities of daily living are activities related to personal care. They include bathing or showering, dressing or undressing, grooming, toileting, continence care, transferring, walking or using mobility aids, eating or feeding assistance. Services must be initiated within 30

Cost	2026 (this year)		2027 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	days of discharge event and utilized within 60 days of discharge for each qualifying event up to the maximum annual allowance. This benefit also allows Caregivers to take a break while the member continues to get care in a safe environment.		days of discharge event and utilized within 60 days of discharge for each qualifying event up to the maximum annual allowance. This benefit also allows Caregivers to take a break while the member continues to get care in a safe environment.	days of discharge event and utilized within 60 days of discharge for each qualifying event up to the maximum annual allowance. This benefit also allows Caregivers to take a break while the member continues to get care in a safe environment. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to **5%** of the allowed amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
SilverSneakers® fitness program	**$0** copayment for SilverSneakers®. The fitness program includes access to participating locations and	Not Covered	No Change	**95%** coinsurance for out-of-network fitness centers. Member is required to pay the full cost at the time of

Cost	2026 (this year)		2027 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	signature group exercise classes led by certified instructors. This benefit also connects you to a support network and virtual resources through live classes, on-demand videos and through a mobile app. Go to SilverSneakers.com to learn more about your benefit.			service when utilizing an out-of-network fitness center. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to **5%** of the allowed amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Skilled nursing facility (SNF) care • For a Medicare-covered stay at a skilled nursing facility, you pay:	**$0** copayment per day for days 1 - 20 **$0** copayment per day for days 21 - 100	**$0** copayment per day for days 1 - 20 **$0 or $218** copayment per day for days 21 - 100 If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a **$0** copayment amount.	No Change	**$0** copayment per day for days 1 - 20 **$0 or $221** copayment per day for days 21 - 100 If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a **$0** copayment amount.
Smoking cessation program	**$0** copayment for additional sessions of smoking and tobacco cessation counseling up to 4 per year.	The in-network provider must be used for this service. If you choose to utilize another	No Change	**$0** copayment for additional sessions of smoking and tobacco cessation counseling up to 4 per year.

Cost	2026 (this year)		2027 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
		provider, you are responsible for all charges.		Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Transportation	**$0** copayment for plan approved location up to 36 one-way trip(s) per year. This benefit is not to exceed 100 miles per one-way trip.	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.	**$0** copayment for plan approved location up to unlimited one-way trip(s) per year. This benefit is not to exceed 100 miles per one-way trip.	**95%** coinsurance for plan approved location up to unlimited one-way trip(s) per year. This benefit is not to exceed 100 miles per one-way trip. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to **5%** of the allowed amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Uniformity Flexibility Non-Emergency Medical Transportation	**$0** copayment for plan approved location up to unlimited one-way trip(s) per year for	The in-network provider must be used for this service. If you choose to	Not Covered	Not Covered

Cost	**2026** (this year)		**2027** (next year)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
	members with a Chronic Kidney Disease (CKD), End Stage Renal Disease (ESRD), or Cancer Diagnosis. This benefit is not to exceed 100 miles per one-way trip.	utilize another provider, you are responsible for all charges.		
Virtual Cardiac Recovery Program (Uniformity Flexibility Benefit)	Not Covered	Not Covered	**$0** copayment for a virtual cardiac recovery program delivered via telehealth, with up to 36 covered sessions to support recovery and reduce the risk of hospital readmission. Coverage is available Post-Inpatient stay for members with Congestive Heart Failure (CHF), Hypertension, Pneumonia or Respiratory Illness.	**95%** coinsurance for a virtual cardiac recovery program delivered via telehealth, with up to 36 covered sessions to support recovery and reduce the risk of hospital readmission. Coverage is available Post-Inpatient stay for members with Congestive Heart Failure (CHF), Hypertension, Pneumonia or Respiratory Illness. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to **5%** of the allowed

Cost	2026 (this year)		2027 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
				amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Vision care • Routine vision services:	**VIS751** **$0** copayment for routine exam up to 1 per year. **$75** combined maximum benefit coverage amount per year for routine exam. **$75** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. OR **$150** maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit	**VIS751** **$0** copayment for routine exam up to 1 per year. **$75** combined maximum benefit coverage amount per year for routine exam. **$75** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.	**VIS697** **$0** copayment for routine exam up to 1 per year. **$40** combined maximum benefit coverage amount per year for routine exam. **$300** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. OR **$400** maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit	**VIS697** **$0** copayment for routine exam up to 1 per year. **$40** combined maximum benefit coverage amount per year for routine exam. **$300** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Cost	2026 (this year)		2027 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	coverage amount is limited to one time use per year.		coverage amount is limited to one time use per year.	
Worldwide coverage • For each emergency transportation by ambulance, you pay:	Not Applicable	**$0 or $335** copayment per date of service If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a **$0** copayment amount.	Not Applicable	**$0 or $325** copayment per date of service If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a **$0** copayment amount.

Section 1.6 Changes to Part D Drug Coverage

Changes to Our Drug Guide

Our list of covered drugs is called a Formulary or Drug Guide. A copy of our Drug Guide is provided electronically. The Drug Guide includes many—but not all—of the drugs that we'll cover next year. If you don't see your drug on this list, it might still be covered.

You can get the *complete* Drug Guide by visiting our website (**Humana.com/druglist**) or calling Customer Care at 800-457-4708 (TTY users call 711).

We made changes to our Drug Guide, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the Drug Guide to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug Guide are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug Guide at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Customer Care at 800-457-4708 (TTY users call 711) for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D Drugs may not apply to you.** We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and you don't get this material by September 30, call Customer Care at 800-457-4708 (TTY users call 711) and ask for the *LIS Rider*.

Drug Payment Stages

There are 3 **drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage.

- ***Stage 1: Yearly Deductible***

  You start in this payment stage each calendar year. During this stage, you pay the full cost of your Part D drugs until you reach the yearly deductible.

- ***Stage 2: Initial Coverage***

  Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date Out-of-Pocket costs reach **$2,400**.

- ***Stage 3: Catastrophic Coverage***

  This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

Stage	**2026** (this year)	**2027** (next year)
Yearly Deductible	If you receive Extra Help, your deductible is **$0**. During this stage, you pay **$0** for all plan-covered Part D drugs. If you **do not** receive Extra Help, the deductible is **$615**. The deductible is **$615** except for covered insulin products and most adult Part D vaccines. During this stage, you pay **$0** cost sharing for drugs on Tier 1, **$0** cost sharing for drugs on Tier 2 and the	If you receive Extra Help, your deductible is **$0**. Refer to your *LIS Rider* insert for your cost sharing amounts. If you **do not** receive Extra Help, the deductible is **$700**. The deductible is **$700** except for covered insulin products and most adult Part D vaccines. During this stage, you pay **$0** cost sharing for drugs on Tier 1, **$0** cost sharing for drugs on Tier 2 and the full cost of drugs on Tier 3, Tier 4, and

Stage	**2026** (this year)	**2027** (next year)
	full cost of drugs on Tier 3, Tier 4, and Tier 5 until you've reached the yearly deductible.	Tier 5 until you've reached the yearly deductible.

Drug Costs in Stage 2: Initial Coverage

We changed the tier for some of the drugs on our Drug Guide. To see if your drugs will be in a different tier, look them up on the Drug Guide.

Not all tiers may include insulin. Please refer to your Prescription Drug Guide to confirm insulin coverage.

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard and preferred cost sharing.

Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply, or for mail-order prescriptions, go to Chapter 6 of your *Evidence of Coverage*.

Once you've paid **$2,400** out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2026 (this year)	**2027** (next year)
Tier 1: Preferred Generic	*Standard cost sharing:* You pay **$0** per month supply at a retail pharmacy. Your cost for a one-month mail-order prescription is **$10**. *Preferred cost sharing*: Your cost for a one-month mail-order prescription is **$0**.	***Standard cost sharing:*** You pay **$0** per month supply at a retail pharmacy. Your cost for a one-month mail-order prescription is **$10**. ***Preferred cost sharing:*** Your cost for a one-month mail-order prescription is **$0**.
Tier 2: Generic:	*Standard cost sharing:* You pay **$0** per month supply at a retail pharmacy. Your cost for a one-month mail-order prescription is **$20**. You pay **25%** up to **$20** per month supply of each covered insulin	***Standard cost sharing:*** You pay **$0** per month supply at a retail pharmacy. Your cost for a one-month mail-order prescription is **$20**. You pay **24%** up to **$20** per month supply of each covered insulin

	2026 (this year)	**2027** (next year)
	product for a mail-order prescription on this tier. *Preferred cost sharing:* Your cost for a one-month mail-order prescription is **$0**.	product for a mail-order prescription on this tier. ***Preferred cost sharing:*** Your cost for a one-month mail-order prescription is **$0**.
Tier 3: Preferred Brand:	*Standard cost sharing:* You pay **25%** per month supply at a retail pharmacy. Your cost for a one-month mail-order prescription is **25%**. *Preferred cost sharing:* Your cost for a one-month mail-order prescription is **25%**.	***Standard cost sharing:*** You pay **25%** per month supply at a retail pharmacy. Your cost for a one-month mail-order prescription is **25%**. ***Preferred cost sharing:*** Your cost for a one-month mail-order prescription is **25%**.
Tier 4: Non-Preferred Drug:	*Standard cost sharing:* You pay **25%** of the total cost per month supply at a retail pharmacy. Your cost for a one-month mail-order prescription is **25%**. *Preferred cost sharing:* Your cost for a one-month mail-order prescription is **25%**.	***Standard cost sharing:*** You pay **25%** of the total cost per month supply at a retail pharmacy. Your cost for a one-month mail-order prescription is **25%**. ***Preferred cost sharing:*** Your cost for a one-month mail-order prescription is **25%**.
Tier 5: Specialty Tier:	*Standard cost sharing:* You pay **25%** of the total cost per month supply at a retail pharmacy. Your cost for a one-month mail-order prescription is **25%**.	***Standard cost sharing:*** You pay **25%** of the total cost per month supply at a retail pharmacy. Your cost for a one-month mail-order prescription is **25%**.

	2026 (this year)	**2027** (next year)
	Preferred cost sharing: Your cost for a one-month mail-order prescription is **25%**.	***Preferred cost sharing:*** Your cost for a one-month mail-order prescription is **25%**.

SECTION 2 How to Change Plans

To stay in HumanaChoice SNP-DE H5216-332 (PPO D-SNP), you don't need to do anything. Unless you sign up for a different Medicare health plan or drug plan, or change to Original Medicare by December 7, you'll automatically be enrolled in our HumanaChoice SNP-DE H5216-332 (PPO D-SNP).

If you want to change plans for 2027 follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from HumanaChoice SNP-DE H5216-332 (PPO D-SNP). Remember, not all Medicare health plans cover prescription drugs. Also, be aware that for many plans, you can't join a Medicare health plan and simultaneously purchase a prescription drug plan.
- **To change to Original Medicare with separate Medicare drug coverage,** you can enroll in a Part D plan, and you'll automatically be disenrolled from HumanaChoice SNP-DE H5216-332 (PPO D-SNP).
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll or visit our website to disenroll online at www.humana.com/member/member-rights/disenrollment-and-cancellation. Call Customer Care at 800-457-4708 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048.
- **To learn more about Original Medicare and the different types of Medicare plans,** visit Medicare.gov, check the *Medicare & You 2027* handbook, call your State Health Insurance Assistance Program (go to Section 4), or call 1-800-MEDICARE (1-800-633-4227).

Section 2.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2027, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2027.

Section 2.2 Are there other times of the year to make a change?

In certain situations, people may have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs

- Have or are leaving employer coverage
- Move out of our plan's service area

Because you have Healthy Louisiana (Medicaid), you can end your membership in our plan by choosing one of the following Medicare options in any month of the year:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare *without* a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 3 Get Help Paying for Prescription Drugs

You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
  - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday - Friday for a representative. Automated messages are available 24 hours a day. TTY users can call 1-800-325-0778.
  - Your State Medicaid Office.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the ADAP program. For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call the ADAP program (the name and phone numbers for this organization are listed in "Exhibit A" in the back of this document). Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027 you do not need to submit a new election

request to continue participating in 2027. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. To learn more about this payment option, call Customer Care at 800-457-4708 (TTY users call 711) or visit Medicare.gov.

SECTION 4 Questions?

Get Help from HumanaChoice SNP-DE H5216-332 (PPO D-SNP)

- **Call Customer Care** at **800-457-4708. (TTY users, call 711.)**

We're available for phone calls from 8 a.m. to 8 p.m., seven days a week from Oct. 1 – Mar. 31 and 8 a.m. to 8 p.m. Monday – Friday from Apr. 1 – Sept. 30. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day. Calls to these numbers are free.

- **Read your *2027 Evidence of Coverage***

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2027. For details, go to the 2027 *Evidence of Coverage* for HumanaChoice SNP-DE H5216-332 (PPO D-SNP). The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at **Humana.com/PlanDocuments** or call Customer Care at 800-457-4708 (TTY users call 711) to ask us to mail you a copy.

- **Visit Humana.com/FindCare**

Our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs (formulary/Drug Guide)*.

Get Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state.

Call your state SHIP to get free personalized health insurance counseling. They can help you understand your Medicare and Medicaid plan choices and answer questions about switching plans. Contact information for your state SHIP is listed in "Exhibit A" in the back of this document.

Get Help from Medicare

- **Call 1-800-MEDICARE (1-800-633-4227)**

  You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.

- **Chat live with Medicare.gov**

  You can chat live at Medicare.gov/talk-to-someone.

- **Write to Medicare**

You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit Medicare.gov**

  The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You* 2027**

  The *Medicare & You 2027 h*andbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Get Help from Medicaid
Call Healthy Louisiana (Medicaid) at the numbers listed in "Exhibit A" in the back of this document for help with Medicaid enrollment or benefit questions.

Exhibit A- State Agency Contact Information

This section provides the contact information for the state agencies referenced in this Annual Notice of Change. If you have trouble locating the information you seek, please contact Customer Care at the phone number on the back cover of this booklet.

LOUISIANA	
SHIP Name and Contact Information	Louisiana Senior Health Information Program 1702 N. Third Street P.O. Box 94214 Baton Rouge, LA 70802 800-259-5300 (toll free) 225-342-5301 (local) 800-259-5301 http://www.ldi.la.gov/SHIIP/
Quality Improvement Organization	Acentra Health 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317 888-315-0636 TTY 711 844-878-7921 (FAX) https://acentraqio.com/aboutus/contact/
State Medicaid Office	Healthy Louisiana (Medicaid) Louisiana Department of Health 628 N. 4th Street Baton Rouge, LA 70802 888-342-6207 (toll free) 225-342-9500 (local) https://ldh.la.gov/healthy-louisiana
AIDS Drug Assistance Program	Louisiana Health Access Program Department of Health & Hospitals Louisiana Health Access Program (LA HAP) 1450 Poydras St Suite 2136 New Orleans, LA 70112 504-568-7474 504-568-3157 (fax) http://www.lahap.org

Insurance ACE Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your personal and health information is important. You do not need to do anything unless you have a request or complaint.

This Notice of Privacy Practices applies to all entities that are part of the Insurance ACE, an Affiliated Covered Entity under HIPAA. The ACE is a group of legally separate covered entities that are affiliated and have designated themselves as a single covered entity for purposes of HIPAA. A complete list of the members of the ACE is available at **https://huma.na/insuranceace**.

We may change our privacy practices and the terms of this notice at any time, as allowed by law, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is nonpublic personal or health information?
Nonpublic personal or health information includes both medical information and personal information, like your name, address, telephone number, Social Security number, account numbers, payment information, or demographic information. The term "information" in this notice includes any nonpublic personal and health information. This includes information created or received by a healthcare provider or health plan. The information relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare.

How do we collect information about you?
We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

What information do we receive about you?
The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history, and your activity on our website. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

How do we protect your information?
We have a responsibility to protect the privacy of your information in all formats including electronic, and oral information. We have administrative, technical, and physical safeguards in place to protect your information in various ways including:
- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our employees about our privacy program and procedures

How do we use and disclose your information?
We use and disclose your information:
- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services

We have the right to use and disclose your information:
- To a doctor, a hospital, or other healthcare provider so you can receive medical care.
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments.

- For healthcare operation activities, including processing your enrollment, responding to your inquiries, coordinating your care, improving quality, and determining premiums.
- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform plan administration functions such as eligibility, enrollment and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations. For example, to allow your plan sponsor to obtain bids from other health plans. Your detailed health information will not be shared with your plan sponsor. We will ask your permission, or your plan sponsor must certify they agree to maintain the privacy of your information.
- To contact you with information about health-related benefits and services, appointment reminders, or treatment alternatives that may be of interest to you. If you have opted out, we will not contact you.
- To your family and friends if you are unavailable to communicate, such as in an emergency.
- To your family and friends, or any other person you identify. This applies if the information is directly relevant to their involvement with your healthcare or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm if the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation.
- To public health agencies, if we believe that there is a serious health or safety threat.
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence.
- In response to a court or administrative order, subpoena, discovery request, or other lawful process.
- For law enforcement purposes, to military authorities and as otherwise required by law.
- To help with disaster relief efforts.
- For compliance programs and health oversight activities.
- To fulfill our obligations under any workers' compensation law or contract.
- To avert a serious and imminent threat to your health or safety or the health or safety of others.
- For research purposes in limited circumstances and provided that they have taken appropriate measures to protect your privacy.
- For procurement, banking, or transplantation of organs, eyes, or tissue.
- To a coroner, medical examiner, or funeral director.

Additional restrictions on use and disclosure for specific types of information:
- Some federal and state laws may restrict the use and disclosure of certain sensitive health information such as: Substance Use Disorder ("SUD") subject to 42 CFR Part 2 ("Part 2") records; Biometric Information; Child or Adult Abuse or Neglect including Sexual Assault; Communicable Diseases; Genetic Information; HIV/AIDS; Mental Health; Reproductive Health; and Sexually Transmitted Diseases.
- If we receive SUD Part 2 records, we will not use or disclose such records, or provide testimony relaying the content of such records, in any civil, criminal, administrative, or legislative proceeding against you unless such disclosure is based on your written consent (separate from your consent for any other use or disclosure), or a court order after notice and an opportunity to be heard is provided to you, as provided by Part 2. A court order authorizing the use or disclosure of SUD Part 2 Records must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

Will we use your information for purposes not described in this notice?
We will not use or disclose your information for any reason that is not described in this notice, without your written permission. You may cancel your permission at any time by notifying us in writing.
The following uses and disclosures will require your written permission:
- Most uses and disclosures of psychotherapy notes and SUD counseling notes
- Marketing purposes
- Sale of personal and health information
- Medical information that is disclosed pursuant to this Notice to an entity that is not a HIPAA-covered entity or business associate, may be subject to disclosure by the recipient and may no longer be protected by federal or state privacy laws (such as HIPAA).

What do we do with your information when you are no longer a member?
Your information may continue to be used for purposes described in this notice. This includes when you do not

obtain coverage through us. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?
We are committed to responding to your rights request in a timely manner.
- Access - You have the right to review and obtain a copy of your information that may be used to make decisions about you. You also may receive a summary of this health information. As required under applicable law, we will make this personal information available to you or to your designated representative.
- Adverse Underwriting Decision - If we decline your application for insurance, you have the right to be provided a reason for the denial.
- Alternate Communications - To avoid a life- threatening situation, you have the right to receive your information in a different manner or at a different place. We will accommodate your request if it is reasonable.
- Amendment - You have the right to request correction of any of this personal information through amendment or deletion. Within 60 business days of receipt of your written request, we will notify you of our amendment or deletion of the information in dispute, or of our refusal to make such correction after further investigation.
- If we refuse to amend or delete the information in dispute, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the information in dispute and what you consider to be the correct information. We shall make such a statement accessible to any and all parties reviewing the information in dispute.*
- Disclosure - You have the right to receive a listing of instances in which we or our business associates have disclosed your information. This does not apply to treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee.
- Notice - You have the right to request and receive a written copy of this notice any time.
- Restriction - You have the right to ask to limit how your information is used or disclosed. We are not required to agree to the limit, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted limitation.

*This right applies only to our Massachusetts residents in accordance with state regulations.

If I believe that my privacy has been violated, what should I do?
If you believe that your privacy has been violated, you may file a complaint with us by calling us at **866-861-2762** any time.
You may also submit a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You can also email your complaint to **OCRComplaint@hhs.gov**. If you elect to file a complaint, your benefits will not be affected, and we will not punish or retaliate against you in any way.

We support your right to protect the privacy of your personal and health information.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

How do I exercise my rights or obtain a copy of this notice?
All of your privacy rights can be exercised by obtaining the applicable forms. You may obtain any of the forms by:
- Contacting us at 866-861-2762
- Accessing our website at **Humana.com** and going to the Privacy Practices link

- Send completed request form to:
  Humana Inc.
  Privacy Office 003/10911
  101 E. Main Street
  Louisville, KY 40202

Notice of Non-Discrimination

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services.
Humana Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).

- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. - 8 p.m., Eastern time. If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with Humana Inc. Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc. Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019**, **800-537-7697 (TDD)**.

California members:
You can also file a civil rights complaint with the California Dept. of Health Care Services, Office of Civil rights by calling **916-440-7370 (TTY: 711)**, emailing **Civilrights@dhcs.ca.gov**, or by mail at: Deputy Director, Office of Civil Rights, Department of Health Care Services, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413. Complaint forms available at: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**.

This notice is available at **www.humana.com/legal/non-discrimination-disclosure**.
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Notice of Availability - Auxiliary Aids and Services Notice

English: Free language, auxiliary aid, and alternate format services are available. Call **877-320-1235 (TTY: 711)**.

አማርኛ [Amharic]፦ነፃ ቋንቋ፣ አጋዥ ማዳመጫ፣ እና አማራጭ ቅርፀት ያላቸው አገልግሎቶችም ይገኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسِّيق البديل مجاناً. اتصل على الرقم **877-320-1235 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛ք **877-320-1235 (TTY՝ 711)** հեռախոսահամարով:

Bǎsɔ́ɔ̀ [Bassa]: Wudu-xwíníín-mú-zà-zà kǔà, hwòdǒ-fɔ́nɔ́-nyɔ̀,, kè nyɔ-ɓɔ̌-po-kà ɓě ɓé wa nyuɛsé wídí péè-péèdò kɔ.̌ Ɓá **877-320-1235 (TTY: 711)**.

বাংলা [Bengali]: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন **877-320-1235 (TTY: 711)** নম্বরে।

简体中文 [Simplified Chinese]：我们可提供免费的语言、辅助设备以及其他格式版本服务。请致电 **877-320-1235**（听障专线：**711**）。

繁體中文 [Traditional Chinese]：我們可提供免費的語言、輔助設備以及其他格式版本服務。請致電 **877-320-1235**（聽障專線：**711**）。

Kreyòl Ayisyen [Haitian Creole]: Gen sèvis lengwistik gratis, èd oksilyè, ak lòt fòma sèvis ki disponib. Rele **877-320-1235 (TTY: 711).**

Hrvatski [Croatian]: Dostupne su besplatne jezične usluge, usluge dodatne pomoći i alternativnog formata. Nazovite **877-320-1235 (TTY: 711)**.

فارسی [Farsi] : خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **877-320-1235 (TTY: 711)** تماس بگیرید.

Français [French]: Des services gratuits d’assistance linguistique, d’aide auxiliaire et de format alternatif sont disponibles. Appelez le **877-320-1235 (ATS : 711)**.

Deutsch [German]: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **877-320-1235 (TTY: 711)**.

Ελληνικά [Greek]: Διατίθενται δωρεάν γλωσσικές υπηρεσίες, βοηθήματα και υπηρεσίες σε εναλλακτικές προσβάσιμες μορφές. Καλέστε στο **877-320-1235 (TTY: 711)**.

ગુજરાતી [Gujarati] : મફત ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. **877-320-1235 (TTY: 711)** પર કૉલ કરો.

עברית [Hebrew]: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **877-320-1235 (TTY: 711)**

हिंदी [Hindi]: निःशुल्क भाषा, सहायक मदद और वैकल्पिक प्रारूप सेवाएं उपलब्ध हैं। **877-320-1235 (TTY:711)** पर कॉल करें।

Hmoob [Hmong]: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **877-320-1235 (TTY: 711)**.

Bekee [Igbo]: Asụsụ n’efu, enyemaka nkwarụ, na ọrụ usoro ndị ọzọ dị. Kpọọ **877-320-1235 (TTY: 711)**.

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Italiano [Italian]: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiamare il numero **877-320-1235 (TTY: 711)**.

日本語 [Japanese]:言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。**877-320-1235 (TTY: 711)** までお電話ください。

ភាសាខ្មែរ [Khmer]៖ សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបាន។ ទូរសព្ទទៅលេខ **877-320-1235 (TTY: 711)** ។

한국어 [Korean]: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다. **877-320-1235 (TTY: 711)** 번으로 문의하십시오.

ພາສາລາວ [Lao]: ມີບໍລິການພາສາ, ອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ຮູບແບບທາງເລືອກອື່ນບໍ່ເສຍຄ່າໃຫ້. ໂທ **877-320-1235 (TTY: 711)**.

Diné [Navajo]: Saad bee áná'álwo', bee haz'áanii, dóó naaltsoos t'áá ajiłii'ígíí bee ak'e'elyaaígíí t'áá jiik'eh hóló. **877-320-1235 (TTY: 711)** bich'į' hodíílnih.

नेपाली [Nepali]: नि:शुल्क भाषा सेवा, सहायक सामग्री र वैकल्पिक ढाँचाका सेवाहरू उपलब्ध छन् । **877-320-1235 (TTY: 711)** मा कल गर्नुहोस् ।

Polski [Polish]: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty. Zadzwoń pod numer **877-320-1235 (TTY: 711)**.

Português [Brazilian Portuguese]: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e outros formatos alternativos. Ligue **877-320-1235 (TTY: 711)**.

ਪੰਜਾਬੀ [Punjabi]: ਮੁਫ਼ਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਹਾਇਤਾ, ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। **877-320-1235 (TTY: 711)** 'ਤੇ ਕਾਲ ਕਰੋ।

Русский [Russian]: Предоставляются бесплатные услуги языковой поддержки, вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру **877-320-1235 (TTY: 711)**.

Español [Spanish]: Los servicios gratuitos de asistencia lingüística, ayuda auxiliar y servicios en otro formato están disponibles. Llame al **877-320-1235 (TTY: 711)**.

Tagalog [Tagalog]: Magagamit ang mga libreng serbisyong pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **877-320-1235 (TTY: 711)**.

தமிழ் [Tamil]: மொழி,, உதவிப் பொருட்கள் மற்றும் மாற்று வடிவமைப்புச் சேவைகள் இலவசமாகக் கிடைக்கின்றன. **877-320-1235 (TTY: 711)** எண்ணை அழைக்கவும்.

తెలుగు [Telugu]: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. **877-320-1235 (TTY: 711)** కి కాల్ చేయండి.

اردو [Urdu]: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال **877-320-1235 (TTY: 711)**۔

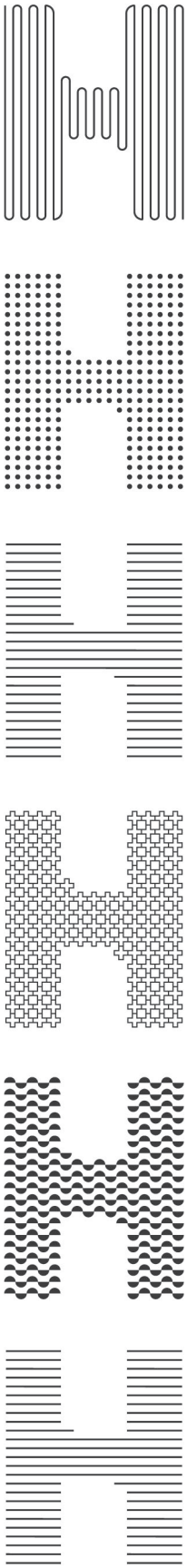
Tiếng Việt [Vietnamese]: Có sẵn miễn phí các dịch vụ ngôn ngữ, hỗ trợ phụ trợ và định dạng thay thế. Hãy gọi **877-320-1235 (TTY: 711)**.

Òyìnbó [Yoruba]: Àwọn iṣẹ́ àtìlẹ́hìn ìrànlọ́wọ́ èdè, àti ọ̀nà kíkà míràn wà lárọwọ́tó lọ́fẹ̀ẹ́.
Pe **877-320-1235 (TTY: 711)**.

This notice is available at **https://www.humana.com/legal/multi-language-support**.

Notes

Notes



Ready to review?
We're ready to help.

Starting October 15, 2026, you can review 2027 plan documents. You'll be able to find the information you need quickly with a simple search, including:

- *Evidence of Coverage* with Member Rights and Responsibilities.
- Plan details, benefits and costs.
- *Provider Directory* that lets you search by specialty, location or condition.
- *Drug Guide* for a list of drugs covered in your plan.

Review your 2027 Medicare plan documents at **Humana.com/Renewal**. To see all of your Humana Medicare plan benefits, go to the *Evidence of Coverage*. Your Medical Benefits are in the Medical Benefits Chart (what's covered) in Chapter 4. Your Pharmacy Benefits are in What you pay for Part D drugs in Chapter 6.

We're here for you. If you need help using these online tools, please call the number on the back of your Humana member ID card.

For paper copies of these documents, call **800-457-4708 (TTY: 711)**, 24 hours a day, seven days a week. Please have your Humana member ID card handy. When asked for the reason you've called, say "*Evidence of Coverage*" or "*Provider Directory*." Please allow up to two weeks to receive the documents by mail.

We update our plans annually based on Medicare funding, policy changes and member priorities.

As a Humana member, you may receive calls about other insurance products. To opt out, call the Customer Care number on the back of your ID card.

Humana®

Y0040_GHZQHEGEN_C

Humana Inc.
P.O. Box 14168
Lexington, KY 40512-4168

H5216332000ANOC27

Important information about changes to your Medicare Advantage and prescription drug plan



Look inside

Here's a summary of your **HumanaChoice SNP-DE H5216-332 (PPO D-SNP)** that takes effect on January 1, 2027.

Humana®

Humana.com
800-457-4708 (TTY: 711)